

An Outpatient Department of Trinity Health Oakland  
9400 Village Place Blvd, Brighton, MI 48116  
Phone: 810-844-7373  
Fax: 810-844-7366

## Inclisiran (Leqvio®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

<b>Patient Name:</b> _____ <b>Patient Address:</b> _____ <b>Patient Phone Number:</b> _____ <b>Date of Birth:</b> ____/____/____ <b>Weight:</b> ____ kg <b>Height:</b> ____ cm <b>Allergies:</b> _____		<b>Primary Insurance:</b> _____ <b>Member ID:</b> _____ <b>Secondary Insurance:</b> _____ <b>Member ID:</b> _____	
<b>Diagnosis</b> <input type="checkbox"/> Pure Hypercholesterolemia, unspecified (E78.00) <input type="checkbox"/> Familial hypercholesterolemia (E78.01) <input type="checkbox"/> Mixed hyperlipidemia (E78.2) <input type="checkbox"/> Other hyperlipidemia (E78.4) <input type="checkbox"/> Acute myocardial infarction (I21) <input type="checkbox"/> ST elevation (STEMI) myocardial infarction of anterior wall (I21.0) <input type="checkbox"/> ST elevation (STEMI) myocardial infarction of inferior wall (I21.1) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____		<b>Labs</b> <input type="checkbox"/> LDL <input type="checkbox"/> LFTs <input type="checkbox"/> Other: _____  <b>Frequency</b> <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____	
Previously tried and failed therapies (include dates): _____			
<b>Inclisiran (Leqvio®)</b> Inject subcutaneously into the abdomen, upper arm, or thigh			
<b>Dose</b> <input type="checkbox"/> 284mg SC injection <input type="checkbox"/> _____ mg		<b>Frequency</b> <b>Induction</b> <input type="checkbox"/> at month 0 and 3  <b>Maintenance</b> <input type="checkbox"/> Every 6 months <input type="checkbox"/> Every _____ months  Date of last dose: ____/____/____	
<b>Pre-Medications and Pre-Protocol</b> (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____		<b>Hydration</b> <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____  _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following

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<b>Flushing Protocol</b> (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care	<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care
<b>Hypersensitivity Panel</b> Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> <li>• <b>Sodium chloride</b> 0.9% bolus 500 mL once as needed for hypotensive management (SBP &lt;90mmHg)</li> <li>• <b>Acetaminophen</b> 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping</li> <li>• <b>Albuterol</b> 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses</li> <li>• <b>Albuterol HFA</b> inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea</li> <li>• <b>Epinephrine</b> injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses</li> <li>• <b>Famotidine</b> injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Diphenhydramine</b> injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom</li> <li>• <b>Diphenhydramine</b> injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Hydrocortisone</b> sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> </ul>	
<div> <div> Provider Name: _____ </div> <div> Provider Signature: _____ </div> </div> <div> <div> Attending Physician Name: _____ </div> <div> Provider NPI: _____ </div> </div> <div> <div> Office Phone Number: _____ </div> <div> Office Fax Number: _____ </div> </div> <p><i>(If ordering provider is an advanced practice practitioner)</i>  <i>Note: This order is valid for 12 months from date of physician signature.</i></p>		